## **Arizona Department of Health Services**Office for Children with Special Health Care Needs

Date:
(Insert Inside address)
Dear:
I would like to take this opportunity to introduce myself to you. My name is
and I am a Family Resource Coordinator with & the Arizona Department of
Health Services (ADHS) Office for Children with Special Health Care Needs (OCSHCN). I received your name
from I would like to contact you regarding the Family Resource Coordination Program. This
program provides Family Resource Coordination for Children and Youth with Special Health Care Needs
(CYSHCN), Traumatic Brain Injury (TBI), and Spinal Cord Injury (SCI) individuals birth to 18 years of years of
age and up to twenty-one years of age once in the program. The Family Resource Coordination is at no cost to
the family. Should you choose to participate in this program you and your family will work with a Family
Resource Coordinator regarding issues surrounding TBI, SCI, and/or other Special Health Care Needs. This
may include but is not limited to providing information, help with transition to school or work, or assisting in
locating professionals in your community.  Please fill out the following information and return in the self addressed stamped envelope.
r lease IIII out the following information and return in the sell addressed stamped envelope.
Yes, I am interested in participating in the ADHS/OCSHCN Family Resource Coordination Program
CYSHCN
CYSHCN TBI SCI
501
Individuals Name
Individuals Name  Name of parent/guardian
Name of parent/guardian
Name of parent/guardian  Contact phone number
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached  No, I am not interested in participating in the ADHS/OCSHCN Family Resource Coordination Program
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached  No, I am not interested in participating in the ADHS/OCSHCN Family Resource Coordination Program at this time. I understand that I may contact you at a later date if I change my mind and wish to participate in the ADHS/OCSHCN Family Resource Coordination Program.
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached  No, I am not interested in participating in the ADHS/OCSHCN Family Resource Coordination Program at this time. I understand that I may contact you at a later date if I change my mind and wish to participate in the ADHS/OCSHCN Family Resource Coordination Program.  I look forward to meeting and working with you. If you have any questions or concerns, please feel free to
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached  No, I am not interested in participating in the ADHS/OCSHCN Family Resource Coordination Program at this time. I understand that I may contact you at a later date if I change my mind and wish to participate in the ADHS/OCSHCN Family Resource Coordination Program.  I look forward to meeting and working with you. If you have any questions or concerns, please feel free to contact me. I can be reached at I sincerely appreciate you taking the time to review
Name of parent/guardian  Contact phone number  Best day of the week & time to be reached  No, I am not interested in participating in the ADHS/OCSHCN Family Resource Coordination Program at this time. I understand that I may contact you at a later date if I change my mind and wish to participate in the ADHS/OCSHCN Family Resource Coordination Program.  I look forward to meeting and working with you. If you have any questions or concerns, please feel free to